STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			_			
		011253	B. WING		12/1	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS S	SENIOR HOME SOLUTIO	ONS INC	AMORE PKW			
0/0/15	SHIMMADV ST	ATEMENT OF DEFICIENCIES	AYETTE, IN 4	PROVIDER'S PLAN OF CORRECTION	<u> </u>	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 000	Initial Comments		N 000			ì
	This visit was for a state home health agency relicensure survey.					
	Survey Dates: December 18 and 19, 2013 Facility #: 011253					l
						l
	Medicaid Vendor #: N	NA				İ
	Surveyor: Bridget Boston, RN, PH Nurse Surveyor, Team Leader Shannon Pietraszewski RN, PH Nurse Surveyor, Team Member Census: 4 Current Skilled patients: 4					
	Quality Review: Joyce January 3, 2	e Elder, MSN, BSN, RN 2014				
	This survey was mod	ified in an IDR 2/19/14. je				
N 440	410 IAC 17-12-1(a) H administration/manag	9	N 440			
	·	tive control, and lines of gation of responsibility down yel shall be: n writing; and				
	ensure there was an olines of authority downwith the the potential	et as evidenced by: review, the agency failed to organizational chart with rn to the patient care level to affect the current 4 I skilled services from the				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/19/2013
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	12/10/2010
ANGELS S	SENIOR HOME SOLUTIO	INS INC	AMORE PKW		
		WEST LAF	AYETTE, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 440	Continued From page	2 1	N 440		
	agency. (Patients #1, #2, #3, and #4)				
	Finding include:				
	provided an organizat	lid not evidence lines of			
N 446	410 IAC 17-12-1(c)(3 administration/manag	·	N 446		
	Rule 12 410 IAC 17-1	2-1(c)(3)			
	Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations.				
	interview, the administicensed practical nurs	ile and policy review and strator failed to ensure 1 of 1 se (LPN) file reviewed (file aluated with the potential to			
	The findings include:				
	an annual performance	ate of hire 1/16/07, lacked ce evaluations for the 2010, 2011, 2012, and			
	supervision of the LPI	PM, the administrator o policy for the frequency of N and that there was no ons available for review for			

Indiana State Department of Health

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/4	9/2013
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZIP CODE	1 12/13	5/2013
		156-A SAG	AMORE PKW			
ANGELS	SENIOR HOME SOLUTIO	WEST LAF	AYETTE, IN 4	7906		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
N 446	Continued From page	2	N 446			
	the years since 2008.					
	void of effective date home care services w by federal and state r standards of practice participate in joint visi	titled "Supervision of Staff" stated, "All staff providing vill be supervised as outlined egulations and accepted Clinical supervisors will ts with staff to observe annually as part of the on process."				
N 456	410 IAC 17-12-1(e) Hadministration/manag	- ·	N 456			
	administration/management Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care.					
	interview, the administ ongoing quality assur improvement program objectively and system evaluate the quality a patient care, resolved improved patient care.	review, policy review, and strator failed to ensure the ance and performance in was designed to matically monitor and appropriateness of lidentified problems, and a for 4 of 4 agency meeting in the potential to affect all				
	The findings include:					
		documents provided as the essment and Improvement				

Indiana State Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		- GONOTICIO	COMPLETED
			7 20.25 (0		
		011253	B. WING		40/40/2042
		011253			12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ANGELS S	SENIOR HOME SOLUTIO	NS INC	AMORE PKW		
		WEST LAF	AYETTE, IN 4	7906	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
N 456	Continued From page	÷ 3	N 456		
14 730	Program dated 11/15/9/25/13 were reviewe evidence the agency systematically monito delivered to the home was developed to idei improve and resolve i objectively reevaluate care was improved. 2. The policy titled "P dated 10/26/10 stated performance improve assess, and improve and other processes. the Plan Do Study Act improvement model to small sample sized, do may be elongated and compliance issues allow the agency to m Data will be systemat process and outcome Identify current level of effectiveness of commareas to be improved stabilize or improve p whether outcomes were and the agency systems are review and the ag	d. The documents failed to objectively and red the patient care health agency patients, nifiy problems and to dentified problems, and de to determine if patient determine if pat	N TOO		
N 458	Information. 410 IAC 17-12-1(f) Ho administration/manag	ome health agency	N 458		

Indiana State Department of Health

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/19/20	13
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS	SENIOR HOME SOLUTIO	NS INC	AMORE PKWY AYETTE, IN 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) OMPLETE DATE
N 458	All employees caring be subject to Indiana registration required to service. Personnel redeliver home health is and shall include doctothe job, including the (1) Receipt of job de (2) Qualifications. (3) A copy of limited IC 16-27-2. (4) A copy of current registration. (5) Annual performant. This RULE is not me 3. The agency policy void of effective date home care services who federal and state in standards of practice participate in joint visit performance at least performance evaluation. Based on personnel finterview, the agency files included annual 1 of 1 personnel file received.	rsonnel practices for upported by written policies. for patients in Indiana shall licensure, certification, or o perform the respective ecords of employees who ervices shall be kept current umentation of orientation to following: scription. criminal history pursuant to clicense, certification, or nee evaluations. It as evidenced by: titled "Supervision of Staff" stated, "All staff providing will be supervised as outlined egulations and accepted Clinical supervisors will ts with staff to observe annually as part of the on process."	N 458			
	practical nurse. (emp	lioyee ⊦)				
	with a date of hire 01/	licensed practical nurse 16/2007, failed to evidenced be evaluation for the years				

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/19/2013	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	12/10/2010	
ANGELS	SENIOR HOME SOLUTIO	INS INC	AMORE PKWY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETE
N 458	Continued From page	2 5	N 458			
	2009, 2010, 2011, 2012, and 2013.					
	2. The Administrator indicated she was not able to locate the annual evaluations for the years 2009, 2010, 2011, and 2012.					
N 472	410 IAC 17-12-2(a) Q A and performance improvement		N 472			
	potential to affect all t	g minutes reviewed with the he agency's patients.				
	The administrative agency's Quality Asset	e documents provided as the essment and Improvement /12, 3/7/13, 7/17/13, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: COMPL			
		011253	B. WING		12/19/2013
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
ANGELS S	SENIOR HOME SOLUTIO	NS INC	SAMORE PKW SAYETTE, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 472	evidence the agency systematically monito delivered to the home was developed to ide improve and resolve i objectively reevaluate care was improved. 2. The policy titled "F dated 10/26/10 stated performance improve and other processes. the Plan Do Study Ac improvement model to small sample sized, d may be elongated and compliance issues allow the agency to m Data will be systemat process and outcome Identify current level of effectiveness of commareas to be improved stabilize or improve p whether outcomes we sindicated there was n review and the agence.	d. The documents failed to objectively and red the patient care health agency patients, ntify problems and to dentified problems, and de to determine if patient hereformance Improvement and the determine if patient hereformance Improvement and the determine if patient hereformance Improvement and the performance of clinical and the process. Due to the performance of clinical and the process. Due to the performance of continuity and the performance and the performanc	N 472		
N 484	Information. 410 IAC 17-12-2(g) Comprovement Rule 12 Sec. 2(g) All		N 484		

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Indiana State Department of Health

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLE	
			A. BOILDING.			
		011253	B. WING		12/1	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS	SENIOR HOME SOLUTIO	INS INC	AMORE PKW			
		WEST LAF	AYETTE, IN 4	7906		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
N 484	Continued From page	e 7	N 484			
	services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.					
	dated 10/26/10 states Nurse: Reports fin the registered nurse a	Skilled Nursing Services" s, "The Licensed Practical dings and observations to and other members of the fination and timely response				
	Based on clinical record review, policy review, and interview, the agency failed to ensure effective communication was established between the nursing staff for 1 of 1 closed clinical records reviewed and the potential to affect all current patients. (# 5)					
	Findings include:					
	evidenced a nurse not employee F, a license documented the patie fresh blood to the left complained of pain ducomplained of sorene observed to have except	, start of care 07/09/13, but dated 7/12/13, written by ed practical nurse, that ent had a scant amount of nephrostomy tube site, uring the dressing change, ess to the buttocks, and was coriation to the inner thigh. vidence the LPN notified the e findings.				
	by employee F evider	d dated 7/15/13 and written nced the patient was open area around the right				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		011253	B. WING		12/19/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE	
ANGELS	SENIOR HOME SOLUTIO	NS INC	AMORE PKW	Y W	
		WEST LAF	AYETTE, IN 4	7906	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 484	Continued From page	8	N 484		
	nephrostomy site. The record failed to evidence the change in the patient was reported to the registered nurse. B. A nurse note dated 7/30/13 and written by				
	employee F evidence kidney spasms and re pain scale of 1-10 wit The clinical record fai	dated 7/30/13 and written by d the patient complained of eported a pain level of 5 on a h 10 being the worst pain. led to evidence employee F to the registered nurse.			
	C. A nurse note dated 8/06/13 and written by employee F evidenced the patient continued to have painful kidney spasms 4 to 5 times per day. The clinical record failed to evidence employee F reported the changes in the patient to the registered nurse.				
		:00 AM, the administrator bring their their own visit very 7-14 days.			
	registered nurse) indi contact her regarding excoriation, and oper nephrostomy site. Er	50 PM, Employee B (a cated Employee F did not the painful bladder spasms, area around the right nployee B indicated she cal notes when Employee F			
	4. The policy titled "Coordination of Patient Services-Interagency" [undated] stated, "All personnel furnishing services, including skilled home health care and hospice, shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Service Plan. This may be done through written and verbal interaction."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/19	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
ANGELS	SENIOR HOME SOLUTIO	INS INC	AMORE PKWY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 486	Continued From page	9	N 486			
N 486	410 IAC 17-12-2(h) Q A and performance improvement		N 486			
	` ,	e home health agency shall s with other health or social ving the patient.				
	This RULE is not met as evidenced by: Based on clinical record review, policy review, and interview, the agency failed to ensure coordination of care occurred with other entities providing services with the potential to affect all patients who receive services from another entity. (#2 and 5)					
	Findings include:					
	1. Clinical Record # 2, SOC 07/19/12, evidenced the patient received services from a personal service agency. The record failed to evidence the agency had coordinated with the personal care attendants who provided 24 hour care.					
	the patient received s service agency. The the agency had coord	5, SOC 07/09/13, evidenced ervices from a personal record failed to evidence linated with the personal assisted the patient with g.				
	coordination of care b	rd also failed to include between the home health and home the patient was 0/04/13.				
	Nurse) on 12/19/13 a did not have document	Employee B (Registered t 12:00 p.m., indicated she ntation of coordination of harging nursing home and endants.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		011253	B. WING			2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTION	DNS INC	ADDRESS, CITY, STATE	N		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 486	Continued From page	e 10	N 486			
	"Purpose: To ensure being provided to pat interchange, reporting care does occur, To reeds or changes ide of services, To evaluatreatment and the eff	" [undated], indicated appropriate, quality care is cients, To establish effective g, and coordination of patient modify the plan to reflect entified to avoid duplication ate the adequacy of ect of services provided, To uation of services and/or				
N 494	410 IAC 17-12-3(a)(1)&(2) Patient Rights	N 494			
	legal representative he of the patient's rights communication. The protect and promote and shall do the follow (1) Provide the patienthe patient's right: (A) in advance of fur or (B) during the initial initiation of treatment (2) Maintain docume	ent with a written notice of nishing care to the patient; evaluation visit before the				
	document review and to ensure patients we Rights found at 410 L beginning of care for reviewed that receive home health agency	et as evidenced by: ord, agency policy, and d interview, the agency failed ere informed of the Patient AC 17-12-3 prior to the 4 of 4 patient records ed skilled services from this and from the separate ncy operated from the same				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011253	B. WING	B. WING		/19/2013	
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ANGELS SE	NIOR HOME SOLUTIO	NS INC	GAMORE PKW FAYETTE, IN 4				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Id 3 cc F 1 1 ttc www.m. F a 2 ttc www.m. F a 3 ttc www.m. F a 4 e i ir. m. w. m. F a 4 e i ir. m. w. m. F a 5 ttc www.m. F a 6 ttc www.m. F a	S, and 5) with the pote current 4 patients admitted to the hequired by 410 IAC 1 was admitted to the Person 2. Clinical record #2, to evidence the patient was informed of the hequired by 410 IAC 1 was admitted to the Person 2. Clinical record #2, to evidence the patient was informed of the hequired by 410 IAC 1 was admitted to the Person 3. Clinical record #3, to evidence the patient was informed of the hequired by 410 IAC 1 was admitted to the Person 3. Clinical record #3, to evidence the patient was informed of the hequired by 410 IAC 1 was admitted to the Person 3. Clinical record #3, to evidence the patient was informed of the hequired by 410 IAC 1 was admitted to the Person 4. Clinical record #5, evidence the patient of the home equired by 410 IAC 1 was admitted to the home	gency name (patient's 1, 2, ential to affect all of the nitted. start of care 4/12/13, failed at or legal representative ome health Patient Rights 7-12-3 when the patient ome health agency. The patient received a Patient was nal Service Agency. start of care 7/19/12 failed at or legal representative ome health Patient Rights 7-12-3 when the patient ome health Patient Rights 7-12-3 when the patient ome health agency. The patient received a Patient was nal Service Agency. start of care 9/13/13 failed at or legal representative ome health Patient Rights 7-12-3 when the client was nal Service Agency. start of care 9/13/13 failed at or legal representative ome health patient Rights 7-12-3 when the patient ome health agency. The patient received a Patient 2/5/12 when the client was	N 494				

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STATE FORM 3EDT11 If continuation sheet 12 of 66

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLI	ETED
		011253	B. WING		12/1	9/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		156-A SAG	AMORE PKW	r W		
ANGELS S	SENIOR HOME SOLUTIO	INS INC	AYETTE, IN 4			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	ı	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 494	Continued From page	e 12	N 494			
	admitted to the Perso	nal Service Agency.				
	admitted to the Personal Service Agency. 5. During an interview on 12/18/13 at 2:35 PM, the director of nursing indicated that when a patient is admitted to the home health agency and was a current client of the personal service agency, the patient / legal representative does not receive a copy of the Home Health Patient Rights document because the personal service agency provided the same Patient Rights document. She indicated the admitting nurse was to verify that the home health patient continued to have a copy of the Patient's Rights document in the home and document in the patient record. 6. The policy titled "Patient Admission Process" dated 10/26/10 stated, "The admission process will include: Provide the patient / caregiver with a copy and an explanation of the Patient Rights."					
N 496	410 IAC 17-12-3(b) P	atient Rights	N 496			
	Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (1) The patient's family or legal representative may exercise the patient's rights as permitted by law.					
	This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to inform patients of the right that their family or legal representative could exercise the patient's rights as permitted by law for 5 of 5 patient records reviewed and the potential to affect all future patients (1, 2, 3, 4 and 5)					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		011253	B. WING		12	2/19/2013
NAME OF P	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE	E, ZIP CODE		
		156-	A SAGAMORE PKWY			
ANGELS	SENIOR HOME SOLUTIO	ONS INC WES	ST LAFAYETTE, IN 479	006		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 496	Continued From page	e 13	N 496			
	Findings include:					
	representative was in Patient Rights require	, start of care (SOC) lence the patient or legal formed of the home health ed by 410 IAC 17-12-3 when ted to the home health				
	2. Clinical Record # 2, SOC 07/19/12, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency.					
	evidence the patient of informed of the home	3, SOC 9/19/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency.				
	4. Clinical record # 4, SOC 11/9/12, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency.					
	evidence the patient of informed of the home	start of care 7/9/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency.				
	Nurse) on 12/18/13 a patients rights were n patients were admitte agency because they when they were admit	Employee B (Registered to 2:35 PM, indicated the lot presented when the lot to the home health received the same rights ted to the separately ervice Agency which was				

Indiana State Department of Health

STATE FORM 3EDT11 If continuation sheet 14 of 66

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	244252				
		011253	B. WING		12/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	.DDRESS, CITY, STATE AGAMORE PKWY AFAYETTE, IN 479	w	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 496	similar name. 7. The policy titled "F	ne location and under a Patient Admission Process"	N 496		
N 498	dated 10/26/10 stated, "The admission process will include: Provide the patient / caregiver with a copy and an explanation of the Patient Rights."				
	N 498 410 IAC 17-12-3(b)(2)(A) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (A) Have his or her property treated with respect.				
	This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to ensure patients were advised of the patient's right to have his property treated with respect for 5 of 5 patient records reviewed and the potential to affect all future patients (1, 2, 3, 4 and 5)				
	Findings include: 1. Clinical record #1, 4/12/13, failed to evid	start of care (SOC) ence the patient or legal			
	representative was in Patient Rights require	formed of the home health d by 410 IAC 17-12-3 when ted to the home health			
	evidence the patient of informed of the home	2, SOC 07/19/12, failed to or legal representative was health Patient Rights 7-12-3 when the patient			

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STATE FORM 3EDT11 If continuation sheet 15 of 66

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
		044252	B. WING		40	/40/2042
		011253			12	/19/2013
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA			
ANGELS	SENIOR HOME SOLUTIO	ONS INC	AGAMORE PKWY AFAYETTE, IN 47			
0/0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF CO	ODDECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 498	Continued From page	e 15	N 498			
	was admitted to the h	ome health agency.				
	evidence the patient of informed of the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted by 410 IAC w	, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient nome health agency. start of care 7/9/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient				
	Nurse) on 12/18/13 a patients rights were in patients were admitted agency because they when they were admit licensed Personal Se	Employee B (Registered to 2:35 PM, indicated the lost presented when the led to the home health received the same rights litted to the separately lervice Agency which was me location and under a				
	dated 10/26/10 stated will include: Provi	Patient Admission Process" d, "The admission process de the patient / caregiver explanation of the Patient				
N 500	410 IAC 17-12-3(b)(2)(B) Patient Rights	N 500			
	Rule 12 (b) The pation	ent has the right to exercise				

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Indiana State Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMP	(X3) DATE SURVEY COMPLETED	
011253 B. WING 12/	19/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 156-A SAGAMORE PKWY W WEST LAFAYETTE, IN 47906		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 500 Continued From page 16 his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. This RULE is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to inform patients of the right to voice grievances regarding treatment or care that is or fails to be furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so for 5 of 5 patient records reviewed and the potential to affect all future patients (1, 2, 3, 4 and 5) Findings include: 1. Clinical record #1, start of care (SOC) 4/12/13, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. 2. Clinical Record # 2, SOC 07/19/12, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency.		

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	011253		B. WING		12/19/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS S	SENIOR HOME SOLUTIO	INS INC	AMORE PKW			
		WEST LAF	AYETTE, IN 4	7906		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
N 500	Continued From page	e 17	N 500			
	required by 410 IAC was admitted to the h	17-12-3 when the patient ome health agency.				
	evidence the patient of informed of the home	•				
	was admitted to the h	17-12-3 when the patient ome health agency.				
	5. Clinical record #5, start of care 7/9/13, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency.					
	6. An interview with Employee B (Registered Nurse) on 12/18/13 at 2:35 PM, indicated the patients rights were not presented when the patients were admitted to the home health agency because they received the same rights when they were admitted to the separately licensed Personal Service Agency which was operated from the same location and under a similar name.					
	dated 10/26/10 stated will include: Provide	Patient Admission Process" d, "The admission process de the patient / caregiver cplanation of the Patient				
N 502	410 IAC 17-12-3(b)(2)(C) Patient Rights	N 502			
	his or her rights as a gency as follows: (2) The patient has (C) Place a complain	ent has the right to exercise patient of the home health the right to the following: int with the department or care furnished by a home				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		011253	B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	ADDRESS, CITY, STATE AGAMORE PKWY N AFAYETTE, IN 479	v		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 502	interview, the agency had been notified of the with the department of turnished by the home given the toll free nun Complaint Hotline for reviewed and the potential patients (1, 2, 3, 4 and Findings include: 1. Clinical record #1 4/12/13, failed to evid representative was in Patient Rights require the patient was admitted agency. 2. Clinical Record #2 evidence the patient of informed of the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home required by 410 IAC was admitted to the home	t as evidenced by: ord and policy review and failed to ensure the patient the right to place a complaint regarding treatment or care the health agency and was riber of the Home Health 5 of 5 patient records rential to affect all future d 5) a, start of care (SOC) rence the patient or legal formed of the home health d by 410 IAC 17-12-3 when ted to the home health for legal representative was realth Patient Rights relative was health Patient Rights	N 502			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		011253	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELO	SENIOD HOME OO! !:=:0	156-A SA	GAMORE PKW	r w		
ANGELS SENIOR HOME SOLUTIONS INC WEST LA			FAYETTE, IN 4	7906		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
N 502	Continued From page	e 19	N 502			
	 N 502 Continued From page 19 5. Clinical record #5, start of care 7/9/13, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. 6. An interview with Employee B (Registered Nurse) on 12/18/13 at 2:35 PM, indicated the patients rights were not presented when the patients were admitted to the home health agency because they received the same rights when they were admitted to the separately licensed Personal Service Agency which was operated from the same location and under a similar name. 7. The policy titled "Patient Admission Process" dated 10/26/10 stated, "The admission process will include: Provide the patient / caregiver with a copy and an explanation of the Patient Rights." 					
N 504	N 504 410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. This RULE is not met as evidenced by:		N 504			
		ord and policy review and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/19/2013
	PROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DRESS, CITY, STA BAMORE PKWY FAYETTE, IN 47	ſ W	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 504	interview, the agency was advised in advanthat would furnish car and services propose 2, 3, 4 and 5) of 5 rector affect all future patinagency. The findings include: 1. Clinical record 1, sfailed to evidence the representative was act the proposed frequentianticipated outcomes. 2. Clinical record 2, Sevidence the patient of advised in advance of frequency of skilled noutcomes. 3. Clinical record # 3 evidence the patient of advised in advance of frequency of skilled noutcomes. 4. Clinical record # 4 evidence the patient of advised in advance of frequency of skilled noutcomes. 5. Clinical record #5, evidence the patient of advised in advance of frequency of skilled noutcomes. 5. Clinical record #5, evidence the patient of advised in advance of frequency of skilled noutcomes.	failed to ensure the patient ce of care of the disciplines e and the frequency of visits d to be provided for 5 (#s 1, ords reviewed with potential ents admitted to the start of care (SOC) 4/12/13, patient or legal dvised in advance of care cy of skilled nurse visits and so or legal representative was a f care the proposed curse visits and anticipated surse visits and anticipated care the proposed curse visits and anticipated curse visits and anti	N 504		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/1	9/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DRESS, CITY, STA GAMORE PKWY FAYETTE, IN 4	(W		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
N 504	proposed on the adm clearly documented. 6. The policy titled "F dated 10/26/10 stated will include: Providence of the proposed on the admiculation of the proposed of the proposed on the admiculation of the proposed on the proposed on the admiculation of the proposed on the proposed of the proposed on the proposed on the proposed on the proposed of the proposed on the pro		N 504			
N 505	his or her rights as a agency as follows: (2) The patient has (D) Be informed about and of any changes in follows: (ii) The patient has the planning of the care. It is advise the patient participate in planning (AA) The care or tree (BB) Changes in the This RULE is not me Based on clinical reconstruction in the planning of their care of any changes in the	ent has the right to exercise patient of the home health the right to the following: but the care to be furnished, in the care to be furnished as the right to participate in the The home health agency int in advance of the right to go the following: atment. The ecare or treatment. The ecare or treatment at the patient right to participate in and the right to be informed to care to be furnished for 5 of the ewed and the potential to the following that (1, 2, 3, 4 and 5)	N 505			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	011253		B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DDRESS, CITY, STATE AGAMORE PKWY AFAYETTE, IN 479	w		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 505	representative was in Patient Rights require the patient was admit agency. 2. Clinical Record #2 evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h. 3. Clinical record #3 evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h. 4. Clinical record #4 evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h. 5. Clinical record #5, evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h. 6. An interview with E Nurse) on 12/18/13 at patients rights were in patients were admitted agency because they when they were admit licensed Personal Se	ence the patient or legal formed of the home health ad by 410 IAC 17-12-3 when ted to the home health 2, SOC 07/19/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 3, SOC 9/19/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 5, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 5, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. Start of care 7/9/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. Employee B (Registered to the oto presented when the dot the home health received the same rights	N 505			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
7.1.12 . 27.11 .			A. BUILDING: _		00	
		011253	B. WING		12/1	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS	SENIOR HOME SOLUTIO	NS INC	GAMORE PKW` FAYETTE, IN 4'			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
N 505	Continued From page 23 7. The policy titled "Patient Admission Process" dated 10/26/10 stated, "The admission process will include: Provide the patient / caregiver with a copy and an explanation of the Patient Rights."		N 505			
N 506	his or her rights as a pagency as follows: (2) The patient has (D) Be informed about and of any changes in follows: (iii) The home health patient of any change including reasonable This RULE is not me Based on clinical reconstructivities, the agency were advised of their changes in the plan or reasonable discharge records reviewed and	ent has the right to exercise patient of the home health the right to the following: but the care to be furnished, in the care to be furnished as agency shall advise the in the plan of care, discharge notice. It as evidenced by: ord and policy review and failed to ensure patients right to be notified of any	N 506			
	 Clinical record #1, start of care (SOC) 4/12/13, failed to evidence the patient or legal representative was informed of the home health Patient Rights required by 410 IAC 17-12-3 when the patient was admitted to the home health agency. Clinical Record # 2, SOC 07/19/12, failed to 					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DDRESS, CITY, STA GAMORE PKWY FAYETTE, IN 47	ſ W	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
N 506	informed of the home required by 410 IAC 1 was admitted to the h 3. Clinical record # 3 evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h 4. Clinical record # 4 evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h 5. Clinical record #5, evidence the patient of informed of the home required by 410 IAC 1 was admitted to the h 6. An interview with E Nurse) on 12/18/13 at patients rights were n patients were admitted agency because they when they were admitlicensed Personal Se operated from the sar similar name. 7. The policy titled "F dated 10/26/10 stated will include: Providence of the home required by 410 IAC 1 was admitted to the home requir	or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 3, SOC 9/19/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 3, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 3, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 3, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency. 5, SOC 11/9/12, failed to or legal representative was health patient Rights 17-12-3 when the patient ome health agency. 5, SOC 9/19/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient ome health agency.	N 506		

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AIND FLAIN (O CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING: _		COWII LETED
		011253	B. WING		12/19/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ANGELS	SENIOR HOME SOLUTIO	INS INC	GAMORE PKWY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 508	Continued From page	e 25	N 508		
N 508	410 IAC 17-12-3(b)(2)(E) Patient Rights	N 508		
	her rights as a patien as follows: (2) The patient has (E) Confidentiality of maintained by the hole home health agency the agency's policies disclosure of clinical results. This RULE is not me	the right to exercise his or t of the home health agency the right to the following: of the clinical records me health agency. The shall advise the patient of and procedures regarding records.			
	legal representative v right to confidentiality the agency's policies disclosure of the clini- admission process ar maintain confidentiali 5 of 5 records review	nd the agency failed to ty of the medical records for ed (# 1, 2, 3, 4, and 5) which by patients and the potential			
	Findings include:				
	patients identified as the they were mainta the records of the sep	clinical records for the 1, 2, 3, 4, and 5 evidenced ined with and combined with parately licensed Personal A) with similar name and me office location.			
	4/12/13, evidenced a	d 1, start of care (SOC) dmission documents from PSA dated 2/12/12, the nd supervision of the			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE	
		156-A SAG	GAMORE PKWY	W	
ANGELS	SENIOR HOME SOLUTIO	WEST LA	FAYETTE, IN 479	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETE
N 508	Continued From page	e 26	N 508		
	documents dated 4/1 of care, medication pr	the home health admission 1/13, physician orders, plans rofiles, and nurse notes from from the home health			
	evidenced admission admission to the PSA agreement, and supe aides from the PSA, I documents dated 7/19 health comprehensive	dated 5/2/12, the service rvision of the attendant care nome health admission 9/12 and included home assessment and ician orders, plans of care,			
	evidenced admission admission to the PSA agreement, and supe aides from the PSA, t comprehensive asses physician orders, plar	a dated 12/5/12, the service rvision of the attendant care he home health asment and reassessments, of care, medication profile, the skilled nurse services			
	evidenced admission admission to the PSA agreement, and supe aides from the PSA, I documents dated 11/9 assessments and rea orders, plans of care, nurse notes from the provided from the hor	a dated 10/24/12, the service rvision of the attendant care nome health admission 9/12, comprehensive ssessments, physician medication profiles, and skilled nurse services me health agency.			
	evidenced admission	d #5, start of care 7/9/13, documents from the			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DRESS, CITY, STA GAMORE PKWY FAYETTE, IN 47	ſ W	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 508	aides from the PSA, a documents including assessment, physicia medication profile, inficare providers, and nurse services provid agency. 2. On 12/18/13 at 2:3 nursing indicated who Service Agency adds health agency, the agseparate home health client record of the Pethe Home Heath Agency additional into one releasier to maintain one 3. The policy titled "Findated 10/26/10 stated will include: Provided assessments includes assessments including assessments and the policy titled assessments."	rvision of the attendant care and home health admission the comprehensive n orders, plan of care, ormation form other health urse notes from the skilled ed from the home health	N 508		
N 510	her rights as a patient as follows: (3) The patient or patient sthe right under In patient's clinical record exceptions apply. The advise the patient or the representative of its patient.	the right to exercise his or tof the home health agency stient's legal representative diana law to access the ds unless certain e home health agency shall	N 510		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/1	9/2013	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	JE ZIP CODE	1 12/1	3/2013	
		156-A SAC	SAMORE PKW				
ANGELS	SENIOR HOME SOLUTIO	WEST LAI	AYETTE, IN 4	7906			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
N 510	interview, the agency or the patient's legal of the right to access the agency's policies the accessibility of clipatient records review affect all future patient. Findings include: 1. Clinical record #1 4/12/13, failed to evid representative was in Patient Rights require the patient was admittagency. 2. Clinical Record #2 evidence the patient of informed of the home required by 410 IAC was admitted to the home required	t as evidenced by: ord and policy review and failed to ensure the patient, representative, was informed the patient's records and of and procedures regarding nical records for 5 of 5 ved and the potential to tts (1, 2, 3, 4 and 5) , start of care (SOC) lence the patient or legal formed of the home health ed by 410 IAC 17-12-3 when ted to the home health 2, SOC 07/19/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient lome health agency. B, SOC 9/19/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient lome health agency. , SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient lome health agency. , SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient	N 510				
		health Patient Rights					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) N		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		011253	B. WING		12/19/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		156-A SAG	SAMORE PKW	(W		
ANGELS S	SENIOR HOME SOLUTIO	INS INC	AYETTE, IN 4			
24.0.15	CLIMMADY CT		1		d own	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	ETE
N 510	10 Continued From page 29		N 510			
	required by 410 IAC 17-12-3 when the patient was admitted to the home health agency.					
	C. Am imtomious suith [
		Employee B (Registered t 2:35 PM, indicated the				
		ot presented when the				
		•				
	patients were admitted to the home health agency because they received the same rights when they were admitted to the separately licensed Personal Service Agency which was					
	•	me location and under a				
	similar name.					
	7. The policy titled "Patient Admission Process" dated 10/26/10 stated, "The admission process will include: Provide the patient / caregiver with a copy and an explanation of the Patient Rights."					
N 512	410 IAC 17-12-3(b)(4) Patient Rights	N 512			
	Rule 12 Sec. 3(b)(4)					
	. , , ,	the right to exercise his or				
		t of the home health agency				
	as follows:	3 ,				
	. ,	the right to be as follows:				
	(A) Free from verbal	l, physical, and				
	psychological abuse.	_:				
	(B) Treated with digi	iity.				
	This RULE is not me	t as evidenced by:				
		ord and policy review, and				
	interview, the agency	failed to ensure the patient				
		ight to be free from verbal,				
		logical abuse and to be				
		r 5 of 5 patient records				
	patients (1, 2, 3, 4 an	ential to affect all future				
	paliellis (1, 2, 3, 4 dll	u <i>5)</i>				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
711272711	or definition	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:	
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS	SENIOR HOME SOLUTIO	ONS INC	GAMORE PKW	Y W	
		WEST LA	FAYETTE, IN 4	7906	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
N 512	Continued From page	e 30	N 512		
	Findings include:				
	representative was in Patient Rights require	, start of care (SOC) lence the patient or legal formed of the home health ed by 410 IAC 17-12-3 when ted to the home health			
	evidence the patient of informed of the home	17-12-3 when the patient			
	evidence the patient of informed of the home	17-12-3 when the patient			
	evidence the patient of informed of the home	, SOC 11/9/12, failed to or legal representative was health Patient Rights 17-12-3 when the patient come health agency.			
	evidence the patient of informed of the home	start of care 7/9/13, failed to or legal representative was health Patient Rights 17-12-3 when the patient some health agency.			
	Nurse) on 12/18/13 a patients rights were n patients were admitte agency because they when they were admi	received the same rights			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		011253	B. WING		12/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	ADDRESS, CITY, STATE AGAMORE PKWY AFAYETTE, IN 479	W	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
N 512	operated from the sar similar name. 7. The policy titled "F dated 10/26/10 stated will include: Provided the same statement of	e 31 The location and under a statient Admission Process* In "The admission process to the patient / caregiver splanation of the Patient	N 512		
N 516	notice in advance of for during the initial evinitiation of treatment, other legal entities who control interest in the CFR § 420.201, 42 C§ 420.206, in effect of This RULE is not me Based on clinical reconstructivities, the agency were informed of the a disclosure of the agrapatient records review affect all future patient Findings include: 1. Clinical record #1, 4/12/13, failed to evid representative was in Patient Rights require	agency shall make at upon request, a written urnishing care to the patient aluation visit before the a listing of all individuals or to have an ownership or agency as defined in 42 EFR § 420.202, and 42 CFR in July 1, 2005. It as evidenced by: ord and policy review and failed to ensure patients right to receive, if requested, ency ownership for 5 of 5 yed and the potential to tts (1, 2, 3, 4 and 5)	N 516		

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indiana C	tate Department of Tie	:aiiii	_		ı	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		011253	B. WING		12/19/2013	
			1		1 12/10/2010	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE		
ANGELS	SENIOR HOME SOLUTIO	ONS INC	SAMORE PKW	Y W		
ANGLLO	DEIGIOR HOME GOLOTIC	WEST LAI	EAYETTE, IN 4	7906		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		E
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	NATE DATE	
N 516	Continued From page	e 32	N 516			
	2. Clinical Record # 2	2, SOC 07/19/12, failed to				
		or legal representative was				
	· · · · · · · · · · · · · · · · · · ·	health Patient Rights				
		17-12-3 when the patient				
	was admitted to the h					
		- ,				
	3. Clinical record # 3	3, SOC 9/19/13, failed to				
	evidence the patient of	or legal representative was				
	informed of the home	health Patient Rights				
	required by 410 IAC 1	17-12-3 when the patient				
	was admitted to the h	nome health agency.				
		, SOC 11/9/12, failed to				
		or legal representative was				
		health Patient Rights				
		17-12-3 when the patient				
	was admitted to the h	iome nealth agency.				
	5 Clinical record #5	start of care 7/9/13, failed to				
		or legal representative was				
	· · · · · · · · · · · · · · · · · · ·	health Patient Rights				
		17-12-3 when the patient				
	was admitted to the h					
	6. An interview with E	Employee B (Registered				
	Nurse) on 12/18/13 a	t 2:35 PM, indicated the				
	patients rights were n	not presented when the				
	patients were admitte	ed to the home health				
		received the same rights				
	when they were admi	•				
		ervice Agency which was				
	•	me location and under a				
	similar name.					
	= - 1					
		Patient Admission Process"				
		d, "The admission process				
		de the patient / caregiver				
		xplanation of the Patient				
	Rights."		1			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		011253	B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	ADDRESS, CITY, STAT AGAMORE PKWY AFAYETTE, IN 47	w		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 518	Continued From page	÷ 33	N 518			
N 518	410 IAC 17-12-3(e) P	atient Rights	N 518			
	distribute written infor advance, concerning directives, including a state law. The home advanced directives in the time of the first horinformation is furnished. This RULE is not me Based on clinical recoveriew, observation, a failed to ensure the pacare, of the Indiana A admission to the hom patient records review affect all future patient 4, and 5).	agency must inform and mation to the patient, in its policies on advance description of applicable health agency may furnish information to a patient at ome visit, as long as the ed before care is provided. It as evidenced by: ord, document, and policy and interview, the agency attent was informed, prior to dvance Directives upon e health agency for 5 of 5 oved and the potential to ts of the agency, (# 1, 2, 3,				
	representative was in Patient Rights require the patient was admit agency. 2. Clinical record # 3 evidence the patient of informed of the home	ence the patient or legal formed of the home health and by 410 IAC 17-12-3 when ted to the home health and some series of the source of the so				
		, SOC 11/9/12, failed to or legal representative was				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011253	B. WING		12/19/2013
		011253			12/19/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
ANGELS S	SENIOR HOME SOLUTIO	NS INC	GAMORE PKWY		
			AFAYETTE, IN 47		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 518	Continued From page	: 34	N 518		
	was admitted to the h 4. Clinical record #5, evidence the patient of informed of the home	ome health agency. start of care 7/9/13, failed to be legal representative was			
	dated 10/26/10 stated will include: Provide	ome health agency. Patient Admission Process" I, "The admission process the the patient / caregiver Explanation of the Patient			
	acceptance of the Pat Patient handbook und Care Services dated (corner of the page ev (Registered Nurse) do	ler the Personal Attendant 05/02/12. The lower right			
	Nurse) on 12/18/13 at patients rights for persame as the home he obtain a new signatur	Employee B (Registered to 2:35 p.m., indicated the sonal care services was the ealth agency and she did not be from the patient or family tient was admitted to home			
N 522	410 IAC 17-13-1(a) P	atient Care	N 522		
	written medical plan of periodically reviewed	edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows:			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING			
		011253	B. WING		12/1	9/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS S	SENIOR HOME SOLUTIO	INS INC	SAMORE PKW			
			AYETTE, IN 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
N 522	Continued From page	e 35	N 522			
	This RULE is not me Based on policy and of interview, the home hensure skilled nursing visits were made in acplan of care (patient 3 consulted for orders provided for orders provided with the potagency's patients. The findings include: 1. The policy titled "Stated 10/26/10 states Initiates the Plan of Condupdates the plan Informs the physic changes in the patien needed. promptly ale changes that suggest care." 2. The undated policy states, "All medication provided to patients in physician." 3. The policy titled "Provided to patients in physician."	t as evidenced by: clinical record review and ealth agency failed to g visits and attendant care ccordance with the medical b) and the physician was prior to providing skilled 5) for 4 of 5 records ential to affect all the Skilled Nursing Services" are and necessary revisions of care and the care plan. Lian and other personnel of t condition and needs as ents the physician to any an eneed to alter the plan of y titled "Physician Orders" has, treatment, and services hust be ordered by a Plan of Care" dated 11/15/10 ervices are furnished under irection of the patient's of care is based on a sement and information and / family Professional ert the physician to any ere the physician to any				
	staff shall promptly ale	ert the physician to any a need to alter the Plan Of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		011253	B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTION	ONS INC	ADDRESS, CITY, STATE AGAMORE PKWY V AFAYETTE, IN 479	v		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 522	patient's physician for Care." 4. Clinical record #1 4/12/13, contained procare dated 8/12/13 through 12/31/13. The patient was hospitalizentered a skilled nure discharged to a privation of the SNF and condition reassessment and continuity of the SNF and condition of th	e 36 all be obtained from the or changes in the Plan of hysician ordered plans of brough 10/11/13 and 11/1/13 The record evidenced the zed on 10/10/13 and then sing facility (SNF) and was atte residence on 11/2/13. Evidenced the director of to the patient on 11/1/3 while ucted the comprehensive reated the plan of care dated 1/13 with orders for skilled "At least every thirty days" for the patient's medications. If the director of nursing a visit on 11/3/13 and pre-set ions. The record failed to hig physician ordered the sprovided and authorized nurse prepared for the	N 522			
	nursing indicated she medications from the administered to the p ordered by the SNF new plan of care and physician on 11/1/13	e SNF on 11/1/13 that were patient as of 11/1/13 and physician, then she wrote the I submitted to the attending . She indicated she did not				
	of the patient and / of from the attending ple health services and p	regarding the current status r obtain a physician order nysician to provide home ore-set the patient's ng to the medication list from				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	SURVEY PLETED	
		011253	B. WING		12	/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTI	ONS INC	ADDRESS, CITY, STATE AGAMORE PKWY N AFAYETTE, IN 479	N		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 522	physician ordered pl through 11/9/13 with two weeks and pers for two hours every record failed to evide were provided as or On 12/18/13 at indicated the attenda the Personal Service and operated from the not provided by the 6. Clinical Record 2 physician orders for to 11/18/13 for skille with medication mand days for 2 months. the patient was seen 10/09/13, 10/16/13, 11/6/13, and 11/13/1 include an order for 7. Clinical Record 5 physician orders for to 09/09/13 for skille with medication man	an of care dated 9/19/13 orders for skilled once every onal care attendant services day, seven days a week. The ence the attendant services dered on the plan of care. 2:30 PM, employee B ant services were provided by es Agency of the same name he same location and were home health agency. 3, SOC 07/19/12, evidenced certification period 09/19/13 d nursing services to assist nagement at least every 30 The clinical record evidenced on 09/20/13, 10/02/13, 10/23/13, 10/24/13, 10/30/13, 13. The record failed to the additional visits. 4, SOC 07/09/13, evidenced certification period 07/09/13 and nursing services to assist nagement at least every 30 the additional visits.	N 522			
	07/10/13, indicated the patient's dressin needed). The clinical patient was not seen to 07/25/13. 8. On 12/18/13 at 2 (Registered Nurse) in have patients in the	A physician order dated for skilled nursing to change g every 3 days and prn (as al record evidenced the n for 9 days between 07/15/13 :35 p.m., Employee B indicated the agency would past change their minds on no visits, so she would write				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS	SENIOR HOME SOLUTIO	INS INC	GAMORE PKW FAYETTE, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
N 522	Continued From page 38		N 522		
	monthly visits versus having to write physician orders frequently.				
N 524	410 IAC 17-13-1(a)(1) Patient Care	N 524		
	of care shall: (A) Be developed in health agency staff. (B) Include all service service is being provice. (B) Cover all pertiner. (C) Include the follow. (i) Mental status. (ii) Types of service. (iii) Frequency and. (iv) Prognosis. (v) Rehabilitation p. (vi) Functional limita. (vii) Activities permit. (viii) Nutritional requi. (ix) Medications an. (x) Any safety mea. injury. (xi) Instructions for.	nt diagnoses. ving: es and equipment required. duration of visits. otential. ations. ted. rements. d treatments. asures to protect against timely discharge or referral. ties specifying length of			
	interview, the agency care included all requ	ord and policy review and failed to ensure the plan of ired elements for 2 of 5 2 and 5) and the potential			
	The findings include:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/19/2013
			1		12/19/2013
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
ANGELS	SENIOR HOME SOLUTIO	NS INC	.GAMORE PKWY AFAYETTE, IN 479		
040.45	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	0.75
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 524	Continued From page 39		N 524		
	physician orders for c to 11/18/13 for skilled with medication mana days for 2 months. Thinclude any safety me against injury as requ 2. Clinical Record # 5	5, start of care 07/09/13,			
	change to nephroston dated 07/10/13 indica change the patient's c as needed. The Plan	2/09/13 and 9//9/13 to sing to assist with dressing my tubes. A physician order ted for skilled nursing to dressing every 3 days and of Care failed to include the directions for treatment and to protect the patient			
	and Employee B indic	0 p.m., the Administrator atted they would not observe for safety if they were only up in the home.			
	indicated "The Plan of full to include: Type all visits / services	n of Care" dated 11/15/10 f Care shall be completed in e, frequency, and duration of Medications, treatments, safety measures to protect			
N 527	410 IAC 17-13-1(a)(2) Patient Care	N 527		
	promptly alert the per	The health care ne home health agency shall son responsible for the fithe patient's care to any			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS	SENIOR HOME SOLUTIO	NS INC	SAMORE PKWY SAYETTE, IN 4:		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 527	Continued From page	: 40	N 527		
	changes that suggest plan of care.	a need to alter the medical			
	interview, the agency physician was notified 1 of 5 records reviews	ord and policy review and			
	Findings included:				
	09/09/13, evidenced, (Licensed Practical N patient had a scant ar left nephrostomy tube change and complain dressing change. The evidenced the patient her buttocks and was	an orders for 07/09/13 to on 07/12/13, Employee F urse) documented the mount of fresh blood to her site during the dressing ed of pain during the e clinical record had also complained of soreness to found to have excoriation to ecord failed to evidence the			
	evidenced the patient the right nephrostomy	visit note dated 7/15/13 had an open area around site. The record failed to n was notified of these			
	evidenced the patient pain level of 5 on a pa being the worst amou	visit note dated 7/30/13 had kidney spasms with a ain scale of 1-10 with 10 nt of pain. The record failed cian was notified of these			

Indiana State Department of Health STATE FORM

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ANCELS	SENIOD HOME SOLUTIO	INC INC 156-A SAG	AMORE PKW	/ W	
ANGELS	SENIOR HOME SOLUTIO	WEST LAF	AYETTE, IN 4	7906	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 527	7 Continued From page 41		N 527		
., 52	c. Skilled nurse visit note dated 8/06/13 evidenced the patient continued to have painful kidney spasms 4 to 5 times per day. The record failed to evidence the physician was notified of these findings.				
	d. An interview with Employee B (Registered Nurse) on 12/18/13 at 2:50 p.m., indicated Employee F did not contact her regarding the painful bladder spasms, excoriation, and open area around the right nephrostomy site. Employee B indicated she would review the clinical notes when Employee F wound turn them in.				
	2. A policy titled, "Skilled Nursing Services" dated 10/26/10, indicated "The Licensed Practical Nurse: Assists the registered nurse to complete the physician plan of care for skilled services Reports findings and observations to the registered nurse and other members of the team to assure coordination and timely response to patient changes or needs Informs MD of findings and observations, after consultation with RN, to assure coordination and timely response to patient changes or needs."				
N 529	410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) for each patient shall (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2)	A written summary report be sent to the:	N 529		

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
		011253	B. WING		12/19	9/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		156-A SAC	SAMORE PKW	Y W		
ANGELS	SENIOR HOME SOLUTIO	ONS INC WEST LAI	AYETTE, IN 4	7906		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETE DATE
	interview, the agency were written per ager clinical synopsis of the condition at least ever clinical records review affect all current 4 part The findings include: 1. Clinical record #1, contained a physician 8/12/13 through 10/12/31/13. The record hospitalized on 10/10 skilled nursing facility an private residence of failed to evidence a critical synopsis of the contained and the cont	ord and policy review and failed to ensure summaries acy policy and including a e patient's status and ry 2 months for 3 of 5 wed with the potential to tients. (#'s 1, 2, and 5) start of care (SOC) 4/12/13 or ordered plan of care dated 1/13 and 11/1/13 through evidenced the patient was 1/13 and then entered a (SNF) and was discharge to on 11/2/13. The record				
	nursing indicated ther for review. 2. Clinical Record # 2 physician orders for complete to 11/18/13 for skilled day summary failed to ordered to have a physician and admission during the previous complete to 11/09/13 for skilled day summary failed to related to kidney spass	11:30 AM, the director of re was no other information 2, SOC 07/19/12, evidenced retrification period 09/19/13 nursing services. The 60 poinclude the patient was evical therapy evaluation and sion to the hospital for colitis retrification period. 5, SOC 07/09/13, evidenced retrification period 09/09/13 nursing services. The 60 poince address the patient's pain sms, open area around the left.				

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Indiana State Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12/19/201	3
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ANGELS	SENIOR HOME SOLUTIO	NS INC	AMORE PKWY AYETTE, IN 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	X5) IPLETE ATE
N 529	relation to the hospital certification period. 4. A policy titled, "Physiciated "A summary the physician no less The summary will propatient's current cond services provided, and the current treatment pertinent changes in the certification."	d the type of infection in lization during the previous ysician Summary" [undated], report will be provided to than every two (2) months. vide a written report of the ition, the treatment and d the patient's response to and / or medications, and	N 529			
N 532	of any significant physical observed or reported of a medical emergent must know in advance to contact. This RULE is not me Based on clinical reconstructiview, the agency physician was notified 1 of 5 records reviewed.	ome health agency only notify a patient's propriate licensed legal representative, if any, sical or mental changes by the patient. In the case ncy, the home health agency e which emergency system t as evidenced by: ord and policy review and	N 532			
	Clinical record 5, 3	SOC (start of care)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ANGELO	SENIOR HOME COLUER	156-A SAC	SAMORE PKW	Y W	
ANGELS	SENIOR HOME SOLUTIO	WEST LA	FAYETTE, IN 4	7906	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE COMPLETE
N 532	Continued From page 44		N 532		
	09/09/13, evidenced, (Licensed Practical N patient had a scant alleft nephrostomy tube change and complain dressing change. The evidenced the patient her buttocks and was the inner thigh. The right physician was notified a. Skilled nurse evidenced the patient the right nephrostomy	e clinical record had also complained of soreness to found to have excoriation to record failed to evidence the			
	b. Skilled nurse visit note dated 7/30/13 evidenced the patient had kidney spasms with a pain level of 5 on a pain scale of 1-10 with 10 being the worst amount of pain. The record failed to evidence the physician was notified of these findings.				
	evidenced the patient kidney spasms 4 to 5	visit note dated 8/06/13 continued to have painful times per day. The record physician was notified of			
	d. An interview with Employee B (Registered Nurse) on 12/18/13 at 2:50 p.m., indicated Employee F did not contact her regarding the painful bladder spasms, excoriation, and open area around the right nephrostomy site. Employee B indicated she would review the clinical notes when Employee F wound turn them in.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		011253	B. WING		12/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DDRESS, CITY, STA GAMORE PKWY LFAYETTE, IN 4:	Y W	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
N 532	10/26/10, indicated "T Nurse: Assists the complete the physicial services Reports find the registered nurse at team to assure coordi to patient changes or findings and observati	lled Nursing Services" dated The Licensed Practical registered nurse to n plan of care for skilled andings and observations to and other members of the nation and timely response needs Informs MD of ions, after consultation with nation and timely response	N 532		
N 539	perform nursing dutie Indiana Nurse Practice Indiana Nurse Practice This RULE is not me Based on clinical record Practice Act review are failed to ensure the reperformed care as ord of 5 clinical records reskilled nurse services all the agency's curre registered nurse services. The findings include: 1. The Indiana Nurse states, "Indiana Code executing regimens dean unlimited license to osteopathic medicine license chiropractor, a licensed podiatrist;"	The registered nurse shall in accordance with the e Act (IC 25-23). It as evidenced by: and and Indiana Nurse and interview, the agency registered nurse only dered by the physician in 2 eviewed of patients receiving with the potential to affect and patients who receive ces. (# 1 and 5) The Practice Act, dated 2005, 25-23-1-1.1 (b) (5) are legated by a physician with the practice medicine or a licensed dentist, a a licensed optometrist, or a	N 539		
	· · · · · · · · · · · · · · · · · · ·				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		I \ /	E SURVEY PLETED
		011253	B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	DNS INC	DDRESS, CITY, STATE AGAMORE PKWY N AFAYETTE, IN 479	N	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 539	4/12/13 contained a paragraph care dated 8/12/13 the through 12/31/13. The patient was hospitalizentered a skilled nurse discharge to an private the passion of care dated 11/1/13 orders for skilled nurse every thirty days" for patient's medications director of nursing math 1/3/13 and pre-set the provided on 11/3/13. B. On 12/18/13 nursing indicated she medications from the other than the patient wrote the new plan of submitted to the atter indicated she did not from the attending phealth services and period medications according provided by the SNF. Clinical Record # 8 physician orders for control of the control of the skilled with medication managraph and days for 2 months. Thurse failed to obtain	ohysician ordered plan of rough 10/11/13 and 11/1/13 are record evidenced the red on 10/10/13 and then sing facility (SNF) and was the residence on 11/2/13. In videnced the director nursing attent on 11/1/3 while in the red the visit as a resment and created the plan attrough 12/31/13 with rough 12/31/13	N 539			

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STATE FORM 3EDT11 If continuation sheet 47 of 66

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		011253	B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	DNS INC	ADDRESS, CITY, STATE AGAMORE PKWY N AFAYETTE, IN 479	N		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
N 539	indicated for skilled n patient's dressing even needed). The clinica	rehensive/admission 7/09/13. rder dated 07/10/13,	N 539			
N 540	Rule 14 Sec. 1(a) (1) are limited to therapy	-	N 540			
	interview, the agency assessments were co records reviewed cre all of the agency's fut	ord and policy review and failed to ensure the initial omplete in 2 (#2, and 5) of 5 ating the potential to affect				
	Assessment" dated 0 addition to general he assessment, the age assessment tool will i Cardiopulmonary star Status/Supportive as: Gastrointestinal and Sensory status, (f.) In	ncy comprehensive nclude: (b.) tus, (c.) Neuromuscular sistance, (d.) Genitourinary status, (e.) stegumentary status, (g.) al/behavioral status, (h.)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
		011253	B. WING		12	/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	•	
ANGELS	SENIOR HOME SOLUTIO	INS INC	GAMORE PKWY			
	T		FAYETTE, IN 479			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 540	Continued From page	e 48	N 540			
	patients medications	e skilled nurse to pre-set the at least monthly. The record 's diagnoses included				
	The comprehensive admission assessment dated 07/19/12, failed to include vital signs, a neuromuscular assessment, ear, eyes, nose, mouth, and throat assessment, balance and gait, appetite, bowel status, and a skin assessment. The assessment identified dementia, the patient was confused regarding medications to take and when, and wanted to continue to drive. The initial assessment failed to evidence the registered nurse identified the primary caregiver, educated and implemented a plan to determine if the patient's blood pressure would be monitored and by whom.					
	physician orders for of 9/09/13 for skilled nur medication managem for 2 months. The coassessment dated 07 vital signs, lung and h	5, SOC 7/09/13, evidenced sertification period 7/09/13 to raing services to assist with ment at least every 30 days comprehensive/admission /09/13 failed to include all meart sounds, ambulation and location / appearance / my tubes.				
	4. On 12/18/13 at 2:3 nursing indicated ther to review.	80 PM, the director of re was no further information				
	to general health state	mprehensive Patient 9/18/12 states, "In addition us / system assessment, the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		l \ /	E SURVEY PLETED	
		011253	B. WING		12	2/19/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE		
		156-A SA	AGAMORE PKWY V			
ANGELS	SENIOR HOME SOLUTIO	INS INC	AFAYETTE, IN 479			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 540	Continued From page	e 49	N 540			
	include: (b.) Cardi Neuromuscular Statu Gastrointestinal and (Sensory status, (f.) In	opulmonary status, (c.) s/Supportive assistance, (d.) Genitourinary status, (e.) tegumentary status, (g.) al/behavioral status, (h.)				
N 541	410 IAC 17-14-1(a)(1)(B) Scope of Services	N 541			
	are limited to therapy practice in the home nurse shall do the foll	health setting, the registered				
	interview, the agency reevaluation of the pa for 3 of 5 clinical reco receiving skilled nurs months with the poter	ord and policy review and failed to ensure the attent's needs was complete rds reviewed of patients ing services for at least 2 intial to affect all the patients ing services longer than 2				
	The findings include:					
	dated 6/12/13 failed t the patient's blood pro	ne updated assessment of oinclude an assessment of				
		14/13 that failed to include				
		videnced the patient was /13 and then entered a				

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AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	011253	B. WING		12/19/2013	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS SENIOR HOME SOLUTIONS INC	3	GAMORE PKWY			
	WEST LA	FAYETTE, IN 47			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
N 541 Continued From page 50		N 541			
skilled nursing facility (SNF an independent private resi. The record evidenced the da visit to the patient on 11/1 and documented the visit as assessment. The comprehand record notes dated 11/1 the assessment included vit the patients medications as attending physician, and the care needs. C. On 12/18/13 at 11:3 nursing indicated there was available. 2. Clinical record 2, start of included a comprehensive re 9/14/12 that failed to include skin assessment. The regist the patient had frequent fall months and required 24 hor failed to evidenced the regist for the cause of the frequent A. The comprehensive 11/16/12 failed to include all sounds, appetite, bowel stars B. The comprehensive 1/18/13 failed to include all sounds, genitourinary and be assessment of ears, nose, fassessment. C. The comprehensive 3/22/13, failed to include all sound, and lung sounds.	dence on 11/2/13. irector nursing made /3 while in the SNF is a comprehensive ensive assessment 1/13 failed to include tal signs, a review of ordered by the expatient's support 30 AM, the director of no further information 4 care 7/19/12, reassessment dated expatient signs and a stered nurse identified signs, ten in the last 2 cur care. The record experiment dated at vital signs, heart tus, and vision. 4 reassessment dated vital signs, heart tus, and vision. 5 reassessment dated vital signs, heart towel status, an chroat, eyes, and skin 6 reassessment dated				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		011253	B. WING		12	2/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
ANGELS	SENIOR HOME SOLUTIO	INS INC	AGAMORE PKWY V			
	I	WEST LA	AFAYETTE, IN 479	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 541	Continued From page	e 51	N 541			
		ensive reassessment dated ude all vital signs and heart				
	E. The comprehensive reassessment dated 7/17/13, failed to include all vital signs, weight, and heart sounds. F. The comprehensive reassessment dated 9/18/13, failed to include vital signs, heart sounds, weight, and lung sounds. H. The comprehensive reassessment dated 11/20/13, failed to include all vital signs, no blood pressure was assessed, and weight.					
	physician orders for o to 09/09/13 for skilled	5, SOC 07/09/13, evidenced ertification period 07/09/13 nursing services to assist agement at least every 30				
	vital signs, lung and h	/09/13 failed to include all neart sounds, ambulation and location / appearance /				
	Registered Nurse cor on 10/8/13 upon retur nursing facility. The r	ecord failed to evidence the impleted the reassessment in to home from a skilled record evidenced employee I nurse, completed the 10/8/13.				
	to general health state agency comprehensive	mprehensive Patient 9/18/12 stated, "In addition us/system assessment, the ve assessment tool will opulmonary status, (c.)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED		
		011253	B. WING		1:	2/19/2013
					12	2/13/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	,		
ANGELS	SENIOR HOME SOLUTIO	ONS INC	\GAMORE PKWY \ \FAYETTE, IN 479			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
N 541	Continued From page	e 52	N 541	<u> </u>	,	
	Neuromuscular Statu Gastrointestinal and (Sensory status, (f.) In Neurological/emotion Activities of Daily Livi conducted based on	s/Supportive assistance, (d.) Genitourinary status, (e.) Itegumentary status, (g.) al/behavioral status, (h.) ng Reassessments are patient needs, physician udgment and/or regulatory				
N 542	410 IAC 17-14-1(a)(1)(C) Scope of Services	N 542			
	are limited to therapy practice in the home nurse shall do the foll	(C) Except where services only, for purposes of health setting, the registered lowing: of care and necessary				
	orders for the skilled medications at least r evidenced the patient to take medications to	start of care 7/19/12, with nurse to pre-set the patients				
	9/14/12 identified the ten in the last 2 mont The record failed to e	nensive reassessment dated patient had frequent falls, hs and had 24 hour care. vidence the registered nurse nplemented a safety plan giver.				
	11/16/12 identified the multiple falls, had poor and twenty-four hour	ensive reassessment dated e patient experienced or judgement and dementia, care was in place due to the care failed to evidence				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		011253	B. WING		12	2/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ANCELS	SENIOD HOME SOLUTIV	ONE INC	AGAMORE PKWY	N		
ANGELS	SENIOR HOME SOLUTION	WEST L	AFAYETTE, IN 479	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 542	implementation of a stherapy services. C. The compret 1/18/13, identified the times in the previous weakness, was "contwheelchair for mobili and the the patient's changed to a stage fevidence the register of care with the primainterventions and patient's who was to monitor thow often, which phy	nensive reassessment dated e patient had fallen four week, had generalized fused," had begun to use a ty when outside the home, chronic kidney disease was our. The record failed to red nurse developed a plan ary caregiver with tient centered goals to a safety and health and with the patient's blood pressure, visician was to be notified, the red dietary restrictions related to	N 542			
	7/17/13, identified the removed and was to The plan of care failed diet needs to ensure to the diagnosis of choral health and healif of all natural teeth are or dentures at time of prevention methods. E. The compress 18/13, identified the aurinary track infection 9/17/13, and "appetite evidenced the patienth hospital on 8/25/13 for released on 8/29/13. included chronic kidn hypertension, recent	nensive assessment dated e patient had all teeth have a full set of dentures. ed to include any change in adequate nutrition as related aronic kidney disease and ang related to the recent loss and without replacement teeth of assessment and infection for the patients oral heath. The patient was diagnosed with and on the previous day, the improving." The record at was admitted to the for rectal bleeding and was The patient's co-morbidities and the patient of the patient's co-morbidities and the patient's co-morbidities and the patient's and had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		011253	B. WING		12/19/201	3
	ROVIDER OR SUPPLIER	156-A SAG	RESS, CITY, STA			
ANGELS	SENIOR HOME SOLUTIO	NS INC WEST LAF	AYETTE, IN 4	7906		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COM	X5) PLETE ATE
N 542	dementia with confus develop, implement, a care with the primary related to the patients the recent diagnosis of promote the patient's the goal as indicated 9/19/13 to 11/18/13 to 5. The policy titled "F dated 10/26/10 stated will include: The recomplete the Assessr 485, Care Plan if indicated, and additional The data gathered she Plan of Care and Cardocument the patient' Identify specific safety vulnerability area. sa documented in the reapplicable. Review the treatment, and care wand obtain input when patient / caregiver of alternative associated provided in the home.	ion. The registered failed to and reevaluate a plan of caregiver and physician a multiple co-morbidities and of urinary track infection to health and safety and attain on the plan of care dated or remain at home. Patient Admission Process degistered nurse shall ment Form, Plan of Care / cated, Medication regime I documents, as required. The almost of the e Plan. Assess and so vulnerability status. The measures relating to the fety measures will be cord and on the care plan as the plan for services, with the patient / caregiver in possible. Inform the any reasonable risk and or divith any procedure in the same plan for services, and the with any procedure in the same plan for services, and the with any procedure in the same plan for services, and the with any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or divith any procedure in the same plan for services and or diviting the same plan for services and the same pla	N 542			

Indiana State Department of Health

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	' '	E SURVEY PLETED
		011253	B. WING		12	2/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	E, ZIP CODE		
ANGELS	SENIOR HOME SOLUTIO	ONS INC	SAGAMORE PKWY			
		WEST	LAFAYETTE, IN 47	906		
PREFIX (EACH DEFICIEN		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 542	Continued From page	e 55	N 542			
	interview, the agency registered nurse updinclude interventions comprehensive asset for 3 of 5 clinical recopotential to affect all and 5)	ord and policy review and realized to ensure the ated the plan of care to for issues identified in the assment and reassessments ords reviewed with the current 4 patients. (# 1, 2,				
	Findings include:					
	1. Clinical record #1, start of care (SOC) 4/12/13, failed to evidence the plan of care dated 8/12/13 through 10/11/13 was based on an updated comprehensive assessment.					
	physician orders for o to 09/09/13 for skilled	5, SOC 07/09/13, evidenced certification period 07/09/13 d nursing services to assist agement at least every 30				
	assessment indicate wound on the gluteal tubes with dressings. include the gluteal wo	mprehensive/admission ad the patient had a covered area and nephrostomy The Plan of Care failed to bund, type of dressings for all for care for all areas.				
	9/12/13, evidenced th	nensive/reassessment dated ne patient had nephrostomy care for 9/10/13 to 12/10/13 ype of dressing and				
	Nurse) on 12/19/13 a	with Employee B (Registered at 12:00 p.m., indicated she assing to the gluteal site.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL		
		011253	B. WING		12/1	9/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	DNS INC	DDRESS, CITY, STAT AGAMORE PKWY AFAYETTE, IN 47	w		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
N 542	3. A policy titled "PI indicated the "Plan of comprehensive asses provided by the patie shall be completed in	ted she was not able to get a	N 542			
N 545	Rule 14 Sec. 1(a) (1) are limited to therapy practice in the home nurse shall do the foll (F) Coordinate service. This RULE is not me	health setting, the registered lowing: ces.	N 545			
	interview, the agency registered nurse notif change in condition for with the potential to a change in condition. Findings included:	failed to ensure the fied the physician of a for 1 of 5 records reviewed ffect all patients with a (Patient # 5)				
	09/09/13, evidenced, (Licensed Practical N patient had a scant a left nephrostomy tube change and complain dressing change. The evidenced the patient	ian orders for 07/09/13 to on 07/12/13, Employee F lurse) documented the mount of fresh blood to her e site during the dressing				

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PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) N 545 Continued From page 57 the inner thigh. The record failed to evidence the physician was notified of these findings. a. Skilled nurse visit note dated 7/15/13 evidence the physician was notified of these findings. b. Skilled nurse visit note dated 7/30/13 evidence the physician was notified of these findings. b. Skilled nurse visit note dated 7/30/13 evidenced the patient had kidney spasms with a pain level of 5 on a pain scale of 1-10 with 10 being the worst amount of pain. The record failed to evidence the physician was notified of these findings. c. Skilled nurse visit note dated 8/06/13 evidenced the patient continued to have painful kidney spasms 4 to 5 times per day. The record	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED		
ANGELS SENIOR HOME SOLUTIONS INC 156-A SAGAMORE PKWY W WEST LAFAYETTE, IN 47906 (X4) ID PREPIX TAGM			011253	B. WING		12	2/19/2013
CAMPIE SENIOR HOME SOLUTIONS INC WEST LAFAYETTE, IN 47906	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	·	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 545 Continued From page 57 the inner thigh. The record failed to evidence the physician was notified of these findings. a. Skilled nurse visit note dated 7/15/13 evidenced the patient had an open area around the right nephrostomy site. The record failed to evidence the physician was notified of these findings. b. Skilled nurse visit note dated 7/30/13 evidenced the patient had kidney spasms with a pain level of 5 on a pain scale of 1-10 with 10 being the worst amount of pain. The record failed to evidence the physician was notified of these findings. c. Skilled nurse visit note dated 8/06/13 evidenced the patient continued to have painful kidney spasms 4 to 5 times per day. The record	ANGELS	SENIOR HOME SOLUTION	INS INC				
the inner thigh. The record failed to evidence the physician was notified of these findings. a. Skilled nurse visit note dated 7/15/13 evidenced the patient had an open area around the right nephrostomy site. The record failed to evidence the physician was notified of these findings. b. Skilled nurse visit note dated 7/30/13 evidenced the patient had kidney spasms with a pain level of 5 on a pain scale of 1-10 with 10 being the worst amount of pain. The record failed to evidence the physician was notified of these findings. c. Skilled nurse visit note dated 8/06/13 evidenced the patient continued to have painful kidney spasms 4 to 5 times per day. The record	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
failed to evidence the physician was notified of these findings. d. An interview with Employee B (Registered Nurse) on 12/18/13 at 2:50 p.m., indicated Employee F did not contact her regarding the painful bladder spasms, excoriation, and open area around the right nephrostomy site. Employee B indicated she would review the clinical notes when Employee F wound turn them in. 2. A policy titled, "Skilled Nursing Services" dated 10/26/10, indicated "The Licensed Practical Nurse: Assists the registered nurse to complete the physician plan of care for skilled services Reports findings and observations to	N 545	the inner thigh. The rephysician was notified a. Skilled nurse evidenced the patient the right nephrostomy evidence the physicial findings. b. Skilled nurse evidenced the patient pain level of 5 on a pabeing the worst amout to evidence the physifindings. c. Skilled nurse evidence the physifindings. c. Skilled nurse evidence the patient kidney spasms 4 to 5 failed to evidence the these findings. d. An interview with these findings. d. An interview with the se findings. d. An interview with the se findings area around the right Employee B indicated clinical notes when E in. 2. A policy titled, "Sk 10/26/10, indicated "Nurse: Assists the complete the physicial service of the serv	record failed to evidence the d of these findings. visit note dated 7/15/13 thad an open area around y site. The record failed to an was notified of these visit note dated 7/30/13 thad kidney spasms with a sain scale of 1-10 with 10 ant of pain. The record failed cian was notified of these visit note dated 8/06/13 the continued to have painful times per day. The record physician was notified of with Employee B (Registered to 2:50 p.m., indicated ontact her regarding the last, excoriation, and open nephrostomy site. If she would review the employee F wound turn them silled Nursing Services" dated on the Licensed Practical registered nurse to an plan of care for skilled	N 545			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SU COMPLE	
		011253	B. WING		12/19	/2013
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANGELS S	SENIOR HOME SOLUTIO	INS INC	SAMORE PKWY SAYETTE, IN 41			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 545	Continued From page	e 58	N 545			
	RN, to assure coordir to patient changes or	nation and timely response needs."				
N 546	N 546 410 IAC 17-14-1(a)(1)(G) Scope of Services		N 546			
	are limited to therapy practice in the home I nurse shall do the foll (G) Inform the physic medical personnel of condition and needs, family in meeting nurs	nealth setting, the registered owing: sian and other appropriate changes in the patient's counsel the patient and sing and related needs, e programs, and supervise				
	agency failed to ensu prior to an admission resumption of care or	ord review and interview, the re the physician was notified of home health services,				
	Findings include:					
	1. Clinical Record # 2 07/19/12, evidenced predification period 09/ nursing services.					
	been sent to the phys stated, "On 01/27/13, dropped to 50/30 w/ [with] a pulse of 44 I will neck the b/p before each ations) et (and) call if				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDIEAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _		GOIVII EETEB
		011253	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
ANGELS	SENIOR HOME SOLUTIO	INS INC	GAMORE PKW		
			FAYETTE, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
N 546	N 546 Continued From page 59				
	been sent to the phys the patient was in the 8/29/13. The clinical orders for resumption				
	2. Clinical Record # 5, SOC 07/09/13, evidenced physician orders for certification period 09/09/13 to 11/09/13 for skilled nursing services.a. The clinical record evidenced the patient				
	had an initial compret assessment on 07/09 record failed to includ				
	note dated 09/18/13, admitted into the hosp 09/23/13, indicated the skilled nursing facility 10/08/13, indicated a	•			
	12:00 p.m., indicated home for another reas asked for the agencie of the nephrostomy to vacation when the pathospital. Employee Ethe skilled nursing factors	Employee B on 12/19/13 at she was at Patient # 5 son and the patient had es services in management ubes and she was on tient returned from the B indicated she was informed cility did not notify the agency he patient had called the			
	1:20 p.m., indicated s	Employee C on 12/19/13 at she was not familiar with the indicated a physician should			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3			X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED	
011253		B. WING		12/19/2013			
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ANGELS SENIOR HOME SOLUTIONS INC 156-A SAGAMORE PKWY W							
			AYETTE, IN 4	7906			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
N 546	Continued From page	e 60	N 546				
	be notified for orders upon returning home from an admission to a hospital or skilled nursing facility. 5. A policy titled "Physician Orders" [undated], indicated "All medications, treatments, and services provided to patients must be ordered by a physician The nurse shall document the implementation of order changes and instructions given to patients."						
N 549	410 IAC 17-14-1(a)(1)(J) Scope of Services	N 549				
	Rule 14 Sec. 1(a) (1)(J) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse. This RULE is not met as evidenced by: Based on personnel file review and interview, the agency failed to ensure personnel was supervised for 1 of 6 personnel files reviewed. (F) Findings include:						
	with a date of hire 01/ an annual performance	licensed practical nurse //16/2007, failed to evidenced ce evaluation for 2009, 2 or any documents related employee F.					
	The Administrator indicated she was not able to locate personnel file F's yearly evaluations for 2009, 2010, 2011, and 2012.						
	2. An interview with the Administrator on						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12	2/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTION	DNS INC	DDRESS, CITY, STATE AGAMORE PKWY N AFAYETTE, IN 479	N		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 549	specific details on ho nurses are supervise 3. A policy dated "Cl indicated "On-site sureceiving services will Registered Nurse to evaluate the implement and the delivery of semethod of supervisio amount and type of controls."	, indicated she did not have w often license practical d. inical Supervision" [undated], pervision of patients I be performed by a direct, demonstrate, and entation of the Plan of Care ervices. The frequency and in will be based on the are provided, patient	N 549			
N 552	complaints, and changes in patient condition." N 552 410 IAC 17-14-1(a)(2) Scope of Services Rule 14 Sec. 1(a) (2) The licensed practical nurse shall perform duties in accordance with the Indiana Nurse Practice Act (IC 25-23). This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure a licensed practical nurse performed duties in accordance with the Indiana Nurse Practice Act for 1 of 1 licensed practical nurse reviewed with the potential to affect all patient receiving services from employee F. (F) Findings included: 1. Clinical record 5, SOC (start of care) 07/09/13, evidenced, on 07/12/13, Employee F (Licensed Practical Nurse) documented the patient had a scant amount of fresh blood to her left nephrostomy tube site during the dressing		N 552			
	change and complair dressing change. Th evidenced the patien					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
		011253	B. WING		12	2/19/2013	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	·		
ANGELS	SENIOR HOME SOLUTION	INS INC	AGAMORE PKWY \ AFAYETTE, IN 479				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE DATE	
N 552	the inner thigh. There indicate the Registere these findings. 2. On 07/15/13, Clini patient had an open a nephrostomy site. The indicate employee Findicate employee nurse and/or the physician of the physician employee nurse and/or the physician or excoriation and op nephrostomy site. En would review the clini wound turn them in. 6. A policy titled, "Sk 10/26/10, indicated "Nurse: Assists the complete the physicial services Reports find the registered nurse at team to assure coord to patient changes or	e was lack of evidence to ed Nurse was notified of cal record 5 evidenced the area around the right nere was lack of evidence to notified the registered nurse of the finding. all record 5 evidenced the lasms with a pain level of 5 10 with 10 being the worst re was lack of evidence to notified the registered nurse of the finding. cal record 5 evidenced the lave painful kidney spasms. There was lack of evidence F notified the registered sician of the finding. 50 p.m., Employee B adicated Employee F did not the painful bladder spasms en area around the right enalth and the painful bladder spasms en area around the right enalth and the painful bladder spasms en area around the right enalth and the painful bladder spasms en area around the right enalth and services when Employee F did Nursing Services dated The Licensed Practical	N 552				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
011253		B. WING		12/19/2013			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 156-A SAGAMORE PKWY W WEST LAFAYETTE, IN 47906							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
N 552			N 552				
N 553	Rule 14 Sec. 1(a) (2) the home health settinurse shall do the followed	(A) Scope of Services For purposes of practice in ng, the licensed practical owing: in accordance with agency	N 553				
	This RULE is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure a licensed practical nurse performed duties in accordance with agency						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
011253		B. WING		12	12/19/2013				
NAME OF P	ROVIDER OR SUPPLIER			TE ZIP CODE	12	19/2013			
	156-A SAGAMORE PKWY W								
ANGELS	SENIOR HOME SOLUTIO	INS INC WEST LA	FAYETTE, IN 4	7906					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE			
N 553	OF PROVIDER OR SUPPLIER STREET ADDR 156-A SAGA WEST LAFA' ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		N 553						
	patient had kidney spasms with a pain level of 5 on a pain scale of 1-10 with 10 being the worst								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		011253	B. WING		12	/19/2013
	ROVIDER OR SUPPLIER SENIOR HOME SOLUTIO	NS INC	DDRESS, CITY, STAT AGAMORE PKWY AFAYETTE, IN 479	w		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 553	amount of pain. Ther indicate employee F is and/or the physician of 5. On 08/06/13, Clini patient continued to have 4 to 5 times per day. to indicate employee nurse and/or the physical field of the	re was lack of evidence to notified the registered nurse of the finding. cal record 5 evidenced the lave painful kidney spasms. There was lack of evidence F notified the registered sician of the finding.	N 553			

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